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Reauthoring the Dominant Narrative of Our Profession

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Introductory Comments by Lynn Kapitan (Editor, 2006-present)

Many times over the past few years since Shirley Riley's untimely death, I have conjured up my memory of her to ask for her opinion on the current state of the profession as it continues to struggle for a secure identity and place in the larger field of mental health care. Re-reading a favorite viewpoint written by Shirley almost 15 years ago (during Susan Spaniol's term as Associate Editor), I find that it is still timely and thought provoking. A dose of Shirley's perspective is always a good antidote for any self-inflicted pity, apathy, or despair in which art therapists might occasionally indulge. I highly recommend "Reauthoring the Dominant Narrative of Our Profession" (1996, *13*[4], 289-292) and hope readers will enjoy this gem of a viewpoint!

Introduction

This is the appropriate time in the evolution of the profession of art therapy to re-create our image and explore a new model of our profession responsive to the postmodern mental health climate. To that end, I would like to take the reader on a fantasy trip and hypothesize what it would be like to move the birth of our occupation forward in time, from the 1950s to the present. After looking at art therapy from this visionary viewpoint, I will offer the reader a sobering look at today's mental health concerns and how they seem to be influencing our clinical practice. The conclusion will incorporate both vision and reality, suggesting how we can move beyond our current concepts of art therapy to re-create a psychotherapeutic service that is both aesthetic and pragmatic. We can enter the postmodern society of mental health providers.

The Time Capsule

If art therapy was conceived in the 1990s, do you think it would be born burdened by the paradoxical question; is art therapy "art as therapy or therapeutic art"? Or is that familiar struggle just an outworn expression of the age of the Fifties, when the traditional analytical view of therapy was "either this way or nothing," rather than, "this way and many more"? I would like to think that this issue, which has been conflictual in the past, would seem pointless, limiting, and diverting attention away from the quality of therapy that we have to offer.

In the postmodern climate of competition that dominates our world of mental health services, I suspect there would be room for all our philosophies under the master umbrella of creativity. We would focus our talents on presenting art therapy as a method of treatment that most successfully gives access to the silent, visual knowing part of our intellect that is often neglected in the process of verbal therapy (Tinnin, 1990). We would assume that creativity is not limited solely to a relationship with the art, and accept a broader definition of creativity that includes how we and our clients can find more successful ways to live in today's social system. I think that the founders of the art therapy profession of the postmodern world would be seen as pragmatically aesthetic or, if you prefer, aesthetically pragmatic, offering the best of all possible worlds.

Our imaginary "founding parents" would be able to explain to other professionals that we conduct therapy in many ways and we follow many theoretical schema. In addition, we are also aware that with the introduction of a visible vocabulary created by the clients, the art therapy will modify theory to make it more personally responsive to each client. The aesthetics of choosing the right theory to "fit" the client's needs turns the therapy into a co-constructed search for a new aspect of the problem-saturated situation. When the client is involved in re-creating his or her view of life, through artwork and reflections on art, the client embraces actions which lead to a "unique outcome" (White & Epston, 1990).

The well-trained art therapist, born in today's world, has a broad knowledge of psychological theories but is not totally committed to any singular belief system. The art of the therapy comes by watching and encouraging the client to find images behind images, uncovering meta messages that surface through the image. Clients may discover how they were taught to accept their discomforting world view as an immutable "truth," their only alternative. It takes no stretch of the imagination to remember the terrible "truths" that some clients have endured. Through their graphic illustrations, clients can develop a new understanding of their trauma and how their hard-fought-for defenses were necessary to make living tolerable in a painful world.

In this postmodern art therapy world I am proposing, art therapists would agree that within every setting offering psychological help, and with every population served, it is necessary for the therapist to wear specialized lenses when viewing clients' needs. For example, it is obvious that we cannot wear inpatient lenses for viewing outpatient treatment (Hoffman, 1990). With each clinical situation only an individualized, unique treatment approach is the "right" way to conduct art therapy. This would eliminate the unnecessary struggle over whether there is greater benefit from a studio art experience, contrasted to a more structured clinical art therapy treatment plan, or conflict over behavioral art

therapy treatment (the structure limits creativity) versus the spontaneous use of art in adult growth groups. There would be acceptance that the same art therapist may become a "different" therapist at different times, in response to different needs of the client. That is to say, the therapist changes his or her approach to conform to the therapeutic needs of the person in treatment. It is not "difference" that is in question; it is rigidity that should be censured.

Consideration of the overwhelming social pressure of our time in history would be built into our system of therapy. There would be no division between case management and "real" therapy. No one would question that the client is a whole person and what is needed in one aspect of his or her life cannot be divided from the rest. The therapist would move quickly to alleviate, within the scope of his or her powers, physical traumas from the client's world, such as abuse, and to provide needed social services and health care information. After these issues are attended to, the client would be less troubled and better able to deal with relationships and intrapsychic problems. It would never occur to our newly invented postmodern art therapist that she or he was in danger of losing her or his identity because social work services were needed immediately, rather than art therapy. It is basic good sense to acknowledge that in extreme crisis the client is focused on survival rather than therapy. Art therapists have no reason to feel threatened; they know art therapy exists because, all through time, people have made art and learned through the experience. There are many clinicians who are so visually oriented that they cannot "not" be art therapists; for these counselors it is impossible not to "see" therapy as well as hear and speak it.

In harmony with the ever-changing circumstances of the postmodern world, art therapists would continue to bring their viewpoint to the public—a synthesis of theory and imagination, of silent and verbal communication. As we embrace the challenge of explaining our profession, we would make it clear to allied professionals that we are not solely an adjunctive methodology. We can equally achieve therapeutic goals and provide complete mental health services as primary therapists, restricted only by the limitations imposed by state licensing laws.

Reality and the Impact of Social Concerns

With this model of the newly created art therapist in mind, let us come back to the here-and-now and see if we are willing to re-create ourselves to fit today's challenges.

For example, it has been documented that children reveal their troubles through the concrete language of art (Malchiodi, 1990; Rubin, 1978). However, if a child's artwork leads to information regarding discrimination at school, the art therapist is obligated to lay aside the art materials and investigate the school system that may be unaware of a traumatic situation that should be addressed. A second example might be a family unable to problem-solve their interpsychic difficulties. When five or six people are living in one room and rotating the use of the bed and floor space, drawing the pressures of cramped quarters and lack of privacy is not enough to reduce their stress. The art therapist may need to accompany the family to a social agency to reinforce and support the coping strengths they have worked on in therapy. She may also need to assist clients as they follow through and encounter the social service worker and housing authorities. Therapy no longer fits the 50-minute format within the confines of the therapist's office. Even the rigid format of California's Medi-cal system allows coverage for the therapist to engage in some external mental health activities that will lead to higher functioning for the client. In private practice these undertakings would probably be covered by the client; however, in my experience, these extra services are more often required for clients that are in a clinic setting.

There are countless other similar crisis situations that could be mentioned, if there was space to do so. Who of us likes to do these managerial things? I venture to say very few. Like it or not, we should take heed that if we choose *not* to enter the fray of social services and managed care systems, we will lose the position of primary therapist to other clinicians who are less aesthetic and more pragmatic. Calling oneself a therapist indicates that we have accepted the role of advocate for our clients and must do what we can in that role.

Not every clinical setting asks the art therapist for social agency involvement in combination with the art therapy, but many do. I worked in an outpatient agency for many years practicing art therapy and I was expected to be the therapist in charge of the family's complete treatment plan. This included therapy, case management, referrals for psychiatric consultations and testing, and school follow-ups. I wrote Medi-cal progress notes with DSM diagnoses, which require that one member of the family be identified as the I.P. I did this, although it was against my beliefs about family systems. My cooperation was needed to help the clinic keep its doors open; my paperwork produced state revenue. However, when the door to my room closed, I conducted "my" therapy without external restrictions. My treatment team knew my approach and were consulted clinically, as needed. Privately, I think it made me a little crazy to record in one manner and practice therapy in another, but I never noticed that it had an effect on the families. I found a way to focus on the family's need for treatment and translate it into language that satisfied stipulations but still gave me the freedom to provide the therapeutic services that my clients required.

In contrast to the long-term, purely psychological treatment plan approach, I have come to believe that we must assist clients on many levels whenever there is a risk of losing vital support systems that give their life dignity. In addition, we must realize that therapy is moving away from the individual session dealing only with intrapsychic difficulties. Most therapists are faced with dealing with the complications of real world challenges: the pregnant teenager; the client ill with cancer or AIDS; the homeless, with their multiple problems; the drug-abusing youth or adult. We cannot limit our services to just the hospital, clinic, or therapeutic school. Outpatient clients go home, hospitalized patients need aftercare; children have to deal with their peers, gangs, and their parents when school is over. The

clients have to accept the advantages and disadvantages of short-term therapy, and so do we.

There are many forms of short-term therapies that are widely used by HMO providers, clinics, hospitals, and persons in private practice. To name a few of these theories we can point to the following: solution-focused therapy (de Shazer, 1988; Friedman, 1993; O'Hanlon & Weiner-Davis, 1988); problem-solving therapy (Haley, 1976); and the MRI brief therapy group in Palo Alto (Fisch, Weakland, & Segal, 1982). The proponents of these approaches feel that the success of therapy has little to do with the time involved in treatment, and clients are generally happy to achieve their goals as promptly as possible. Some clinicians feel that the populations that are not benefiting from these brief therapies are those professionals who deal with more severely damaged clients, such as clients with schizophrenic disorders, severely abused clients, those with dissociate disorders or borderline personality disorder, and other chronically distressed persons. Their care has often been shifted to day treatment centers where the objectives and goals are developed to fit their needs. These patients receive medical therapy through the use of prescribed drugs and complementary psychotherapy to evaluate the changes sought through medication. The psychiatrist handles the medication and sets the treatment goals but often does not spend much time with the patient. As we look at the changing mental health scene, it becomes apparent that along with the people we serve, we are not only art therapists, we are also members of a society in transition and must develop our skills to meet the prevailing demands of the times.

Where are we going?

I am confident that a large majority of our graduate programs are offering an adequate background in psychological theory, practice, and principles of art therapy. My questions are: "Are they educating students to join the mainstream of today's mental health care system? Are our students being taught how to join managed care (or whatever will replace health insurance in the future) in order to survive?" If the next generation of art therapists does not endure, neither will the profession. If there is no place in the job market for art therapy, how can we ply our trade? I do not particularly like this limiting change, but I feel that our first responsibility is to our students and their future. We can teach our students and trainees the pragmatics of providing treatment, as well as the aesthetics of conducting therapy. I am sure that the dominantly creative character of the persons in our field will make them better "problem solvers." It takes imagination and visualization to find new ways "to beat the system" and not compromise on the quality of treatment that brings comfort to our clients! What is often overlooked is that creativity also brings satisfaction to the creator, no matter from where it springs. There are many ways to be artful and therapeutic in the world of managed care. We have a broad palette of approaches in the art therapy room; we must not be afraid to step outside that room into the hassle of our mental health environment. It is not as though we have a choice.

Theories and Treatment

In the current literature and personal reflections of many of the foremost thinkers in the field of family therapy (the field with which I am most acquainted), there is a major shift in the focus of theories and personal involvement of the therapist. There is a thrust to bring the many approaches to treatment under a broad encompassing theory, not discarding but including the variety of belief systems that have developed in this field (Breulin, Schwartz, Kune-Karrer, 1992). Perhaps we should do the same.

Theorists are offering more comprehensive approaches to treatment; many of these theories emphasize language and restorying histories (Anderson & Goolishian, 1988); co-creating therapy with clients (Hoffman, 1993); using a reflecting team to demystify the sessions (Thomm, 1985); and externalizing the problem, viewing it as an entity separate from the individual (White & Epston, 1990). All these approaches are ways of conducting therapy that share the goal of depathologizing the client or family. This attitude takes a wide perspective of the problem, admits the involvement of the therapist, and offers relief in an effective and shorter time frame. These changes may have come about partially in response to the economic pressures from society, but they are theoretically sound and operate from a base of respected systemic thinking.

I think we have to make similar shifts in our thinking. Why not go past the issue of how we do art therapy? There are many roads to success, and there is no question that what we do is useful. We do not have to contrive an entirely new formula for art therapy; we only have to work together to find an aesthetic/pragmatic explanation of our expertise for those who question it. We can preserve the skills we have and add others that we know we need to survive. We can remain the same and be different simultaneously; we lose nothing!

A recent issue of the journal *Networker* (1995) devoted attention to the necessity of bringing a variety of skills to the field of mental health that we might ordinarily avoid. A practice consultant is quoted:

> Many therapists are great clinicians, but terrible business people, temperamental artists in a profession that is changing from being an art to an industry. These changes create a lot of cognitive dissonance. Some clinicians can make the change and learn to explain themselves to the business community…but for others, altering themselves to fit the pattern of consumer capitalism cuts too close to the marrow of their personal identity. Some even leave the field rather than make these compromises. (Lawless, 1995, p. 24)

Turning Theory into Political Practice

Over my 20 years of practice and supervising, I have seen many students and colleagues establish their own identities in the mental health field. Their successes went further than substantiating their skills as therapists and demonstrating how the addition of art made for improved treatment. They demonstrated that they could write excellent case

progress notes (consistent with state standards), support a child in a school I.E.P. (individual education plan), fight the county worker for justice for a client, argue with a divorce lawyer in defense of a naive woman client, work with a family in denial of the demise of their son with AIDS, and accept the role of activist for the good of the clients. The hands-on willingness of these men and women art therapists to encounter the mental health system, in every aspect, has radically reeducated the local community in Southern California. Both consumers and providers have a new understanding of the capabilities of the art therapist which has transcended the sometimes stereotyped and misunderstood view of our place in the mental health system.

What has caused me distress and left me puzzled is that these very persons were not always embraced and accepted by our own art therapy community. There appears to be a notion that they are degraded because they are not "really" doing art therapy. I think we should adopt some of the wisdom of social workers. They have no problem with their identity; they just stay together and gain more power every year. If they lack expertise in an area of service, they invent another subspecialty of social work! I think we should do the same. In truth, we are doing that very thing and should take pride in all the workplaces infiltrated by art therapists and remade to meet their own creative standards.

In the same vein of enhancing our survival skills, another question can be posed. Why not get some sort of allied license until our own comes along? Why not boast that we can expand our educational programs to include information demanded by the state licensing boards and still not dilute the art therapy core of every course? Why not be comfortable with who we are, and know that we can use the current available licenses, such as MFCT or counseling, to keep ourselves alive? There are many good reasons why art therapists should continue to work together both clinically and politically with allied professions without the fear of danger or compromise.

There is a theoretical concept that may be very useful to further the move toward an altered vision of art therapy. This way of thinking is called social constructionism, which has been incorporated into modern-day individual and family psychotherapy, both by psychiatrists and psychotherapists (Anderson & Goolishian, 1988). A fundamental concept they propose is that we all have invented a basic reality of the events of our life based on the prevailing myths and belief systems we have been taught. However, in dialogue with another we can learn to see aspects of our history that have been disregarded. This dialogue opens the possibility for a new interpretation of our story and creates the potential for a new and more positive ending to the dominant narrative. This concept has been called "re-authoring a life script" (White, 1990).

This concept could be used to reauthor the current invented reality of what an art therapist is and what she or he can and cannot do. A fresh dialogue could free us to move on and embrace and enhance all aspects of our work with clients and ultimately with ourselves. What we believe in becomes our truth, and since truth has many facets, we can invent a reality that takes advantage of the challenge presented by today's society. The historical "founding parents" of our profession established our identity in the face of disbelief from many professionals. However, they took the encouragement they received from others and held on to their own convictions. They believed in the positive qualities that art therapy could bring to treatment. We face a different challenge in the preservation of our identity. We can do it best by recognizing that although change is threatening, it also offers new opportunities to redefine our profession and continue to offer our unique talents to clients and the profession of mental health.

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